

STATE OF COLORADO
DEPARTMENT OF LABOR AND EMPLOYMENT
DIVISION OF WORKERS' COMPENSATION

AUTHORIZATION FOR RELEASE OF INFORMATION TO THIRD PARTIES

Re:

Claimant Name: _____
(Applicant)

Claimant SSN: _____
(Applicant social security number)

Requestor Name: _____
(Employer name AND Employer representative)

The above referenced claimant authorizes limited access to all workers' compensation files on record as stated below. This authorization shall remain in effect for ninety days from the date of claimant's signature, unless claimant notifies the Division of Workers' Compensation in writing before such time, that claimant revoking said authorization.

Information provided shall be limited to:

- Workers' Compensation
- Date of Injury
- Part of Body
- Employer

Claimant
(Applicant's Signature)

Date Claimant Signed

Must be signed and dated by the claimant/applicant.

Notarization is required

STATE OF COLORADO

)ss,

When using an embossed seal, please shade before faxing

COUNTY OF DENVER

Subscribed and sworn to before me this

_____ day of _____, 20 _____

by _____
(Print name of claimant)

(Signature of Notary Public)

My commission expires: _____